



# SPEECH NOTES

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### **SPEECH NOTES FOR THE HEALTH INFORMATICS CONFERENCE Melbourne Convention Centre Tuesday, 2 August 2005**

Many of the best ministerial speeches take as their theme "more good news from the Howard Government". This won't be that kind of speech, not because there isn't good news about the use of IT to deliver better health care but because, as yet, it remains a work half done. As the Boston Consulting Group noted last year, "expectations for an electronically-enabled health care system are high, but so is frustration about the pace of progress".

The Government's e-health objectives are clear: First, to provide health professionals with the connectivity needed for swift access to information and financial transfers. Second, to ensure that patients can claim their rebate online from their doctor's surgery. Third, to ensure that private hospital patients can access information - about rebates and particular "gap" payments for specific procedures - and receive one consolidated bill. Fourth, and most important, to ensure that every significant health record is available in a comprehensible form to every patient and, with patient authorisation, to any treating health professional.

Ultimately, better use of IT is about saving lives - not just more convenience for patients and the people treating them, important though that is. An integrated health record could prevent some of the estimated 3,500 avoidable deaths a year in hospitals due to inadequate record keeping and incomplete information. Online access could avoid repetitive radiology and pathology tests and save a significant part of the \$3 billion a year spent on diagnostics. Electronic funds transfer from the Health Insurance Commission into people's bank accounts could spare millions of patients the inconvenience of form-filling and trips to Medicare offices.

If team care is not to get bogged down in cycles of meetings and missed phone calls, if there is to be a more seamless patient transition from primary care to acute care to residential care; if chronically ill patients are to avoid repetitive history-taking and invasive diagnostic tests, the health system needs to make much better use of IT. Better use of IT won't necessarily make people less sick, but it will enable them to be treated more effectively with less cost. Better use of IT is no substitute for a growing health workforce, but it will enable health professionals to maximise their clinical effectiveness. Better use of IT will help to prevent over-referrals and over-prescribing. It will help to minimise medical mistakes. It will facilitate phone triage and remote consultations. It will enable patients to control their own health data without having to keep it in their heads. Better use of IT is no panacea, but there's scarcely a problem in the health system it can't improve. It's hard to over-sell the ultimate benefits of IT in health care. On the other hand, it's easy to underestimate the logistical and cultural shifts necessary before IT can be used to its full potential.

Unfortunately, even the real prospect of saving lives, reducing costs and enhancing convenience has been slow to overcome inertia and the prejudice that change is usually for the worse. Thinking about this speech, I tried to recall recent instances of the use of IT in my own health treatment. From memory, there were several electronically-produced prescriptions, one health check using computer-generated prompts, one data base search for an equivalent generic medicine and one Medicare card-swipe producing a rebate cheque posted to home without any other paperwork - out of, perhaps, a dozen GP visits. By contrast, one of my staff said that the three doctors she'd seen in the past decade had all used a PC during consultations to make case notes and find files. One had even e-mailed test results. Still, it's a mixed record. The \$600 million the Commonwealth Government has spent on GP IT since 1999 has undoubtedly improved the back-office systems of medical practices but it hasn't yet made the sort of difference that most patients would notice.

E-health is a high priority for the Howard Government. It was the subject of my first scripted speech as health minister. The subsequent 20 months have seen solid progress: the establishment of the National E-Health Transition Authority; the launch of a Medicare smart card in Tasmania; the beginnings of HealthConnect in South Australia; and the substantial completion of many of the trials necessary to enable the widespread effective use of IT in health care.

Still, important goals remain elusive: most patients can't claim their rebate electronically from doctor's surgeries; few funds provide members with a consolidated bill; and people can't yet access their MBS and PBS data online from their home PC. Although an internet-linked computer sits on the desk of almost every health professional in the country, as yet it can only access in-house health systems. In particular, there's no system of securely extracting patient information from discrete health records and making it available in an accessible form to any authorised user. Almost every doctor's surgery now has EFTPOS facilities - which can swipe everything except the Medicare card.

Obviously, the use of IT in health poses different problems from its use in the finance sector. Even so, the finance sector's ability to move billions of dollars, in millions of transactions, at tens of thousands of different outlets, between hundreds of thousands of accounts, with dozens of financial institutions, plus customers' capacity to access financial data via the internet, poses a challenge to our own sector that we have not yet met. If the finance sector can not only exchange people's financial information, but also transfer their money in ways which provide security and protect privacy, why is health still a cottage industry by comparison? If the best and brightest Australians really do gravitate to medicine, as our clinical achievements suggest, why can't the health sector get closer to matching the finance sector's administrative efficiency and customer convenience?

The shift to larger medical practices with full-time managers, practice nurses and on-site allied health professionals means doctors are necessarily becoming less IT-averse. Last week's Health Ministers' Conference decision to establish a national safety and quality commission will make it more important for doctors to have comprehensive records, access to the best possible information retrieval systems, and useable checklists against avoidable mistakes. The development of an effective national chronic disease strategy will be virtually impossible without convenient information-sharing systems.

Understandably enough, the health sector - particularly the medical profession - has put clinical outcomes ahead of administration. Soon, clinical and administrative excellence will become inseparable. As health care becomes more sophisticated and depends more and more on multidisciplinary teams, clinical excellence will become much harder to achieve without linked-up information systems. IT will become integral to service delivery as well as to practice management. It won't just be the receptionist or the practice accountant who needs to use IT. It will become an integral feature of the doctor's work routine. That's why changing the attitudes of doctors, and the current culture of medical practice, is as important as designing the best possible systems. For health professionals, the imaginative leap required is to see themselves as patient managers as well as simply clinicians. For systems designers and marketeers, the imaginative challenge is to ditch the assumption that the advantages of IT are self-evident; and try harder to show doctors how technology can make their lives easier.

One of the reasons for the comparatively slow take-up of IT systems in health is that patients and taxpayers gain the immediate benefits while doctors and health institutions face the immediate costs, despite government incentives through the *Practice Incentive* and *Broadband for Health* programmes. To many doctors, e-health is a "hassle". Computers cost money and often seem to have limited clinical usefulness. It takes time to install a system and entering data can seem to take time away from patients. For most doctors, existing "low-tech" record systems offer adequate details on patient history, so what's the point of a system which can summon other health professionals' records? It might even make it easier for rivals to poach their patients. For its part, government has not always been clear about the different circumstances in which it wanted to build health IT systems, or pay the private sector to do so, or treat the development of health IT systems as simply a standard part of doing business in the sector. As a result, systems designers have hesitated to become involved or have waited for a subsidy while government considered its next move.

The UK Government, admittedly with a somewhat different medical culture and a much more monolithic health organisation, is currently spending some \$15 billion (or the cost of three fully-equipped aircraft carriers) to create a giant IT network for the entire National Health Service. Despite this, last week's *Economist* reported that only 5 per cent of clinicians say they have been adequately consulted and only 21 per cent of GPs had any enthusiasm for the project.

In Australia, about 40 per cent of GP practices are now using HIC Online to make bulk-billing claims; but just four per cent give their patients electronic access to the rebate (and in most cases, this means a cheque in the mail rather than an electronic bank credit). Partly, this is because software is only periodically upgraded. Partly, it's because EFTPOS cards need to be "interrogated" to provide bank account details which then need to be communicated to Medicare. But also it's the persistence of the cottage industry mindset; and institutional fears that making the rebate easy to claim could undermine bulk-billing.

So far, about a third of private health funds are using the ECLIPSE software system designed to ensure that patients can access information about potential gap payments and receive a consolidated bill. Partly, this is because doctors can only access the system if they enter contractual arrangements with funds. Mostly, it's because some big funds have been more focussed on their own internal IT systems than on joining a common public access system, despite its obvious advantages for their members.

So far, nearly 2,000 Tasmanians have been issued with the new Medicare smart card, even though at present the card only enables holders to access information, via kiosks in Medicare offices, about their safety net entitlements and immunisation status. There's no technical reason why this, plus much else, couldn't be accessible online using standard Medicare technology. Smart cards are an important part of the Government's long-term IT programme, but the Health portfolio's current focus is on using the existing system to its full capacity.

As well, the Government is currently talking to the banks about the technicalities of one-swipe access to the Medicare rebate; and talking to funds and the medical profession about what can be done to remove obstacles to using ECLIPSE. For its part, the Government intends to remove the bar to participation by doctors who don't have formal agreements with the funds; and will talk to Medibank Private about how quickly it can join the system. For their part, the funds and the profession need to understand that the Government won't proceed with further ECLIPSE spending unless they are fully committed to use the system.

Some fundamental lessons have emerged from the experience of the past couple of years. The first is that government's most effective role is to set standards rather than to build systems. The second is that financial incentives alone are not enough for many doctors to incorporate IT into their practices. The third is that only a move from pilot projects to the real thing will persuade most doctors to work on a keyboard rather than an index card; and to use the internet rather than the postal system.

IT companies waiting for NHS-style mega-contracts to build a stand-alone Australian e-health system are likely to be disappointed. In pursuing HIC Online, for instance, the Government is much more likely to consider say, a modest loading per rebate paid electronically, than multi-million dollar deals to build IT systems which people may not use. The Government would prefer to pay for outcomes not systems. We're more interested in results than engineering. In pursuing HealthConnect, the Government is more inclined to work with IT-based medical record providers than to re-invent the wheel or second-guess the market.

If, as expected, there are significant savings to taxpayers from better use of IT in the health sector, some of these gains could flow to doctors through higher Medicare rebates or greater PIP payments. Even so, the fact that existing incentives have not been enough to encourage doctors to make better use of their computers is not necessarily an argument for more of the same. If social security recipients are required to have bank accounts to enable electronic funds transfer, it doesn't seem unreasonable to require doctors to have online records and claiming systems as a condition of practice accreditation, especially as this becomes a more important aspect of high quality health care. After a suitable transition period, participation in HealthConnect and HIC Online could become mandatory. Naturally, the Government would prefer not to compel the use of IT and will continue to work with the profession to avoid it. Even so, the time is fast approaching when the failure to use IT in health care will seem like the failure to install airbags in cars.

The work of the National E-Health Transition Authority signals the Government's clearer focus and the increased tempo of change. It is jointly funded by the Commonwealth and the states and territories. Its board comprises the nation's health department secretaries and a CEO with a mandate to make a difference. Its job is not to create an e-health system but to create a framework which allows the market to create one. Since late last year, NEHTA has helped to establish inter-operability protocols plus an agreed national framework for the format of patient records and clinical terminology.

The take-up of the Government's \$48 million broadband initiative is another sign of momentum. Almost 90 per cent of Australia's 4,000 pharmacies and 35 per cent of our 7,000 general practices now have access to business grade broadband connectivity. Discussions between my department and the radiology and pathology professions indicate that these test results should certainly be available online within 12 months.

Today, I officially opened the Epworth Hospital in Eastern Melbourne. All case notes are online. All doctors are using terminals. Patients' food orders are taken on an electronic note pad. There will be a complete e-dispensing system once the legislative barriers to electronic signatures on prescriptions are removed.

In South Australia, comprehensive patient records can now be accessed from any terminal in any public hospital. When patients present at emergency departments, the OACIS system gives triage nurses a summary health record with the capacity to call-up more detailed information. Doctors and nurses can enter case notes via terminals on every ward, with bedside terminals soon to be available. Discharge summaries are automatically prepared to fax to patients' GPs and will soon be delivered online. Under a trial to commence soon, OACIS will be linked to participating GPs so that clinicians can draw on a comprehensive medical record.

It's rarely possible to replicate systems used in other sectors, but it's usually instructive to consider what's made them succeed. The MYOB system, for instance, was a market response to the more complex needs of small business in the era of GST. The system was neither built by government nor directly paid for by government. In health, an equivalent comprehensive system has not yet emerged, although Medical Director could be a candidate. One reason perhaps is the expectation that, in health, government should be the great provider. The Government has no plans to remove existing IT incentive payments or to cease pursuing already commenced IT strategies, but there's no reason why an \$80 billion a year industry can't sustain a dynamic health IT sector without further subsidy.

In health IT, government's best role is to make things possible rather than to make them happen. As minister, I will do everything I can to create a benign environment but it's mostly up to the private market to develop the systems and the medical profession to use them if Australia's health care is to remain second-to-none. Government can't be the great provider but it should be the great facilitator, so the private sector can deliver e-health solutions.